Primary Care Network (PCN) Co-Payment Schedule

Benefit	Co-Pay Amount * The maximum co-pays you will be required to pay are $1,000.00 per person/per calendar year
Physician Visit (Pregnancy related services not covered)	$5 co-pay per visit
Hospital Emergency Room (Not all emergencies are covered by PCN, see your PCN Member Handbook for more information.)	$30 co-pay per visit for emergencies
Emergency Transportation	No co-pay – limited to emergency transportation
Medical Equipment and Supplies	10% co-pay for covered services
Pre-existing Condition Waiting Period	No Waiting Period
Pharmacy (Four prescriptions per month)	$5 co-pay for prescriptions on preferred list; 25% of the allowed amount for drugs not on preferred list
Laboratory	5% co-pay of the allowed amount if over $50
X-rays	5% co-pay of the allowed amount if over $100
Dental Services Including: examinations, x-rays, cleanings and fillings	10% co-pay of allowed amount
Vision Screening (One eye exam per year, prescription eyeglasses and contacts not included)	$5 co-pay; one eye exam per year
General preventive services and health education	

Note: Services not included are outpatient hospital services, pregnancy related services, mental health services, occupational therapy, physical therapy and chiropractic services.

This is only a summary of PCN benefits and co-payments; plan restrictions may apply.

Promote Prevent Protect
Utah Department of Health